Great Lakes Optometry Patient Info Check-In

Date:_____________________

Pt. Name: ______________________________ D.O.B: ______________________

Phone Number:______________________ Cell Landline

Is it okay to text this number? Yes No

Primary Medical Doctor: _____________________

Medical Conditions your medications are for:

____

Eye Conditions:

____

Eye Surgeries:

Type of Eye Surgery	Date

Medications:

____

(We can copy a medication card instead of writing it! Just let us know!)

Allergies:

____

There is a **family history** of (please check):

□ Cataracts □ Glaucoma □ Macular Degeneration

□ Hypertension □ Diabetes □ Cancer □ Heart Disease Other:_______________

Social History (please check):

Alcohol use: □ None □ Drinks socially □ Daily

Tobacco use: □ None □ Former Smoker □ Current smoker